(B) if provided for under applicable State law, any other requirements on providers and facilities regarding the amounts such providers and facilities may, with respect to an item or service, charge a participant, beneficiary, or enrollee of such plan or coverage with respect to which such a provider or facility does not have a contractual relationship for furnishing such item or service under the plan or coverage after receiving payment from the plan or coverage for such item or service and any applicable cost sharing payment from such participant, beneficiary, or enrollee; and

(C) the requirements applied under section 300gg–111 of this title; and

(2) information on contacting appropriate State and Federal agencies in the case that an individual believes that such a provider or facility has violated any requirement described in paragraph (1) with respect to such individual.

(July 1, 1944, ch. 373, title XXVII, § 2799A–5, as added Pub. L. 116–260, div. BB, title I, § 116(a), Dec. 27, 2020, 134 Stat. 2878.)

§ 300gg–117. Other patient protections

(a) Choice of health care professional

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) Access to pediatric care

(1) Pediatric care

In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(2) Construction

Nothing in paragraph (1) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

(c) Patient access to obstetrical and gynecological care

(1) General rights

(A) Direct access

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. Such professional shall agree to otherwise adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(B) Obstetrical and gynecological care

A group health plan or health insurance issuer described in paragraph (2) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under subparagraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(2) Application of paragraph

A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in this paragraph is a group health plan or health insurance coverage that—

(A) provides coverage for obstetric or gynecologic care; and

(B) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(3) Construction

Nothing in paragraph (1) shall be construed to—

(A) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

(July 1, 1944, ch. 373, title XXVII, § 2799A–7, as added Pub. L. 116–260, div. BB, title I, § 102(a)(2), Dec. 27, 2020, 134 Stat. 2770.)

EFFECTIVE DATE

Section applicable with respect to plan years beginning on or after Jan. 1, 2022, see section 102(e) of Pub. L. 116–260, set out as an Effective Date of 2020 Amendment note under section 8902 of Title 5, Government Organization and Employees.

§ 300gg–118. Air ambulance report requirements

(a) In general

Each group health plan and health insurance issuer offering group or individual health insurance coverage shall submit to the Secretary, jointly with the Secretary of Labor and the Secretary of the Treasury—

(1) not later than the date that is 90 days after the last day of the first calendar year be-

ginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in section 106(d) of the No Surprises Act, the information described in subsection (b) with respect to such plan year; and

(2) not later than the date that is 90 days after the last day of the calendar year immediately succeeding the plan year described in paragraph (1), such information with respect to such immediately succeeding plan year.

(b) Information described

For purposes of subsection (a), information described in this subsection, with respect to a group health plan or a health insurance issuer offering group or individual health insurance coverage, is each of the following:

(1) Claims data for air ambulance services furnished by providers of such services, disaggregated by each of the following factors:

(A) Whether such services were furnished on an emergent or nonemergent basis.

(B) Whether the provider of such services is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program, or tribally operated program in Alaska.

(C) Whether the transport in which the services were furnished originated in a rural or urban area.

(D) The type of aircraft (such as rotor transport or fixed wing transport) used to furnish such services.

(E) Whether the provider of such services has a contract with the plan or issuer, as applicable, to furnish such services under the plan or coverage, respectively.

(2) Such other information regarding providers of air ambulance services as the Secretary may specify.

(July 1, 1944, ch. 373, title XXVII, §2799A–8, as added Pub. L. 116–260, div. BB, title I, §106(b)(1), Dec. 27, 2020, 134 Stat. 2852.)

REFERENCES IN TEXT

Section 106(d) of the No Surprises Act, referred to in subsec. (a)(1), is section 106(d) of div. BB of Pub. L. 116–260, which is set out as a note below.

REPORTING REQUIREMENTS REGARDING AIR AMBULANCE SERVICES

Pub. L. 116–260, div. BB, title I, §106, Dec. 27, 2020, 134 Stat. 2851, provided that:

''(a) REPORTING REQUIREMENTS FOR PROVIDERS OF AIR AMBULANCE SERVICES.—

''(1) IN GENERAL.—A provider of air ambulance services shall submit to the Secretary of Health and Human Services and the Secretary of Transportation—

''(A) not later than the date that is 90 days after the last day of the first calendar year beginning on or after the date on which a final rule is promulgated pursuant to the rulemaking described in subsection (d), the information described in paragraph (2) with respect to such plan year; and

''(B) not later than the date that is 90 days after the last day of the plan year immediately succeeding the plan year described in subparagraph (A), such information with respect to such immediately succeeding plan year.

''(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), information described in this paragraph, with respect to a provider of air ambulance services, is each of the following:

''(A) Cost data, as determined appropriate by the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, for air ambulance services furnished by such provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services.

''(B) The number and location of all air ambulance bases operated by such provider.

''(C) The number and type of aircraft operated by such provider.

''(D) The number of air ambulance transports, disaggregated by payor mix, including—

''(i)(I) group health plans;

''(II) health insurance issuers; and

''(III) State and Federal Government payors; and

''(ii) uninsured individuals.

''(E) The number of claims of such provider that have been denied payment by a group health plan or health insurance issuer and the reasons for any such denials.

''(F) The number of emergency and nonemergency air ambulance transports, disaggregated by air ambulance base and type of aircraft.

''(G) Such other information regarding air ambulance services as the Secretary of Health and Human Services may specify.

''(b) REPORTING REQUIREMENTS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS.—

''(1) PHSA.—[Enacted this section.]

''(2) ERISA.—

''(A) IN GENERAL.—[Enacted section 1185*l* of Title 29, Labor.]

''(B) CLERICAL AMENDMENT.—[Amended table of contents of the Employee Retirement Income Security Act of 1974.]

''(3) IRC.—

''(A) IN GENERAL.—[Enacted section 9823 of Title 26, Internal Revenue Code.]

''(B) CLERICAL AMENDMENT.—[Amended analysis preceding section 9811 of Title 26, Internal Revenue Code.]

''(c) PUBLICATION OF COMPREHENSIVE REPORT.—

''(1) IN GENERAL.—Not later than the date that is one year after the date described in subsection (a)(2) of section 2799A–8 of the Public Health Service Act [42 U.S.C. 300gg–118], of section 723 of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1185*l*], and of section 9823 of the Internal Revenue Code of 1986 [26 U.S.C. 9823], as such sections are added by subsection (b), the Secretary of Health and Human Services, in consultation with the Secretary of Transportation (referred to in this section as the 'Secretaries'), shall develop, and make publicly available (subject to paragraph (3)), a comprehensive report summarizing the information submitted under subsection (a) and the amendments made by subsection (b) and including each of the following:

''(A) The percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program, municipality-sponsored program, hospital-independent partnership (hybrid) program, or independent program.

''(B) An assessment of the extent of competition among providers of air ambulance services on the basis of price and services offered, and any changes in such competition over time.

''(C) An assessment of the average charges for air ambulance services, amounts paid by group health plans and health insurance issuers offering group or individual health insurance coverage to providers of air ambulance services for furnishing such services, and amounts paid out-of-pocket by consumers, and any changes in such amounts paid over time.

''(D) An assessment of the presence of air ambulance bases in, or with the capability to serve, rural

areas, and the relative growth in air ambulance bases in rural and urban areas over time.

''(E) Any evidence of gaps in rural access to providers of air ambulance services.

''(F) The percentage of providers of air ambulance services that have contracts with group health plans or health insurance issuers offering group or individual health insurance coverage to furnish such services under such plans or coverage, respectively.

''(G) An assessment of whether there are instances of unfair, deceptive, or predatory practices by providers of air ambulance services in collecting payments from patients to whom such services are furnished, such as referral of such patients to collections, lawsuits, and liens or wage garnishment actions.

''(H) An assessment of whether there are, within the air ambulance industry, instances of unreasonable industry concentration, excessive market domination, or other conditions that would allow at least one provider of air ambulance services to unreasonably increase prices or exclude competition in air ambulance services in a given geographic region.

''(I) An assessment of the frequency of patient balance billing, patient referrals to collections, lawsuits to collect balance bills, and liens or wage garnishment actions by providers of air ambulance services as part of a collections process across hospital-owned or sponsored programs, municipality-sponsored programs, hospital-independent partnership (hybrid) programs, tribally operated programs in Alaska, or independent programs, providers of air ambulance services operated by public agencies (such as a State or county health department), and other independent providers of air ambulance services.

''(J) An assessment of the frequency of claims appeals made by providers of air ambulance services to group health plans or health insurance issuers offering group or individual health insurance coverage with respect to air ambulance services furnished to enrollees of such plans or coverage, respectively.

''(K) Any other cost, quality, or other data relating to air ambulance services or the air ambulance industry, as determined necessary and appropriate by the Secretaries.

''(2) OTHER SOURCES OF INFORMATION.—The Secretaries may incorporate information from independent experts or third-party sources in developing the comprehensive report required under paragraph (1).

''(3) PROTECTION OF PROPRIETARY INFORMATION.—The Secretaries may not make publicly available under this subsection any proprietary information.

''(d) RULEMAKING.—Not later than the date that is one year after the date of the enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services, in consultation with the Secretary of Transportation, shall, through notice and comment rulemaking, specify the form and manner in which reports described in subsection (a) and in the amendments made by subsection (b) shall be submitted to such Secretaries, taking into consideration (as applicable and to the extent feasible) any recommendations included in the report submitted by the Advisory Committee on Air Ambulance and Patient Billing under section 418(e) of the FAA Reauthorization Act of 2018 (Public Law 115–254; 49 U.S.C. 42301 note prec.).

''(e) CIVIL MONEY PENALTIES.—

''(1) IN GENERAL.—Subject to paragraph (2), a provider of air ambulance services who fails to submit all information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, shall be subject to a civil money penalty of not more than $10,000.

''(2) EXCEPTION.—In the case of a provider of air ambulance services that submits only some of the information required under subsection (a)(2) by the date described in subparagraph (A) or (B) of subsection (a)(1), as applicable, the Secretary of Health and Human Services may waive the civil money penalty imposed under paragraph (1) if such provider demonstrates a good faith effort (as defined by the Secretary pursuant to regulation) in working with the Secretary to submit the remaining information required under subsection (a)(2).

''(3) PROCEDURE.—The provisions of section 1128A of the Social Security Act (42 U.S.C. 1320a–7a), other than subsections (a) and (b) and the first sentence of subsection (c)(1), shall apply to civil money penalties under this subsection in the same manner as such provisions apply to a penalty or proceeding under such section.

''(f) UNFAIR AND DECEPTIVE PRACTICES AND UNFAIR METHODS OF COMPETITION.—The Secretary of Transportation may use any information submitted under subsection (a) in determining whether a provider of air ambulance services has violated section 41712(a) of title 49, United States Code.

''(g) ADVISORY COMMITTEE ON AIR AMBULANCE QUALITY AND PATIENT SAFETY.—

''(1) ESTABLISHMENT.—Not later than the date that is 60 days after the date of the enactment of this Act [Dec. 27, 2020], the Secretary of Health and Human Services and the Secretary of Transportation, shall establish an Advisory Committee on Air Ambulance Quality and Patient Safety (referred to in this subsection as the 'Committee') for the purpose of reviewing options to establish quality, patient safety, and clinical capability standards for each clinical capability level of air ambulances.

''(2) MEMBERSHIP.—The Committee shall be composed of the following members:

''(A) The Secretary of Health and Human Services, or a designee of the Secretary, who shall serve as the Chair of the Committee.

''(B) The Secretary of Transportation, or a designee of the Secretary.

''(C) One representative, to be appointed by the Secretary of Health and Human Services, of each of the following:

''(i) State health insurance regulators.

''(ii) Health care providers.

''(iii) Group health plans and health insurance issuers offering group or individual health insurance coverage.

''(iv) Patient advocacy groups.

''(v) Accrediting bodies with experience in quality measures.

''(D) Three representatives of the air ambulance industry, to be appointed by the Secretary of Transportation.

''(E) Additional three representatives not covered under subparagraphs (A) through (D), as determined necessary and appropriate by the Secretary of Health and Human Services and Secretary of Transportation.

''(3) FIRST MEETING.—Not later than the date that is 90 days after the date of the enactment of this Act, the Committee shall hold its first meeting.

''(4) DUTIES.—The Committee shall study and make recommendations, as appropriate, to Congress regarding each of the following with respect to air ambulance services:

''(A) Qualifications of different clinical capability levels and tiering of such levels.

''(B) Patient safety and quality standards.

''(C) Options for improving service reliability during poor weather, night conditions, or other adverse conditions.

''(D) Differences between air ambulance vehicle types, services, and technologies, and other flight capability standards, and the impact of such differences on patient safety.

''(E) Clinical triage criteria for air ambulances.

''(5) REPORT.—Not later than the date that is 180 days after the date of the first meeting of the Committee, the Committee, in consultation with relevant

experts and stakeholders, as appropriate, shall develop and make publicly available a report on any recommendations submitted to Congress under paragraph (4). The Committee may update such report, as determined appropriate by the Committee.

''(h) DEFINITIONS.—In this section, the terms 'group health plan', 'health insurance coverage', 'individual health insurance coverage', 'group health insurance coverage', and 'health insurance issuer' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).''

§ 300gg–119. Increasing transparency by removing gag clauses on price and quality information

(a)[1] Increasing price and quality transparency for plan sponsors and group and individual market consumers

(1) Group health plans

A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from—

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.], including, on a per claim basis—

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.].

(2) Individual health insurance coverage

A health insurance issuer offering individual health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, or other service provider offering access to a network of providers that would directly or indirectly restrict the health insurance issuer from—

(A) providing provider-specific price or quality of care information, through a consumer engagement tool or any other means, to referring providers, enrollees, or individuals eligible to become enrollees of the plan or coverage; or

(B) sharing, for plan design, plan administration, and plan, financial, legal, and quality improvement activities, data described in subparagraph (A) with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.].

(3) Clarification regarding public disclosure of information

Nothing in paragraph (1)(A) or (2)(A) prevents a health care provider, network or association of providers, or other service provider from placing reasonable restrictions on the public disclosure of the information described in such paragraphs (1) and (2).

(4) Attestation

A group health plan or a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary an attestation that such plan or issuer of such coverage is in compliance with the requirements of this subsection.

(5) Rules of construction

Nothing in this section shall be construed to modify or eliminate existing privacy protections and standards under State and Federal law. Nothing in this subsection shall be construed to otherwise limit access by a group health plan, plan sponsor, or health insurance issuer to data as permitted under the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990 [42 U.S.C. 12101 et seq.].

(July 1, 1944, ch. 373, title XXVII, § 2799A–9, as added Pub. L. 116–260, div. BB, title II, § 201(a), Dec. 27, 2020, 134 Stat. 2890.)

REFERENCES IN TEXT

Section 264(c) of the Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(1)(B), (C), (2)(B), (5), is section 264 of Pub. L. 104–191, which is set out as a note under section 1320d–2 of this title.

The Genetic Information Nondiscrimination Act of 2008, referred to in subsec. (a)(1)(B), (C), (2)(B), (5), is

[1] So in original. There is no subsec. (b).